

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2011	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 259 WEST HARRISON ST MOORESVILLE, IN46158			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00093118.</p> <p>Complaint IN00093118 - Substantiated. Federal/state deficiencies related to the allegation are cited at F225 and F226.</p> <p>Survey dates: July 07 and 08, 2011</p> <p>Facility number: 000398 Provider number: 155564 AIM number: 100291110</p> <p>Survey team: Kimberly Perigo, RN</p> <p>Census bed type: SNF: 18 SNF/NF: 51 Total: 69</p> <p>Census payor type: Medicare: 12 Medicaid: 40 Other: 17 Total: 69</p> <p>Sample: 03</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/11/11 by Jennie</p>			F0000	<p>The Mooresville facility respectfully requests paper compliance. Please accept the following plan of correction for F-Tag 225 and F-Tag 226 as our credible allegation of compliance.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0225 SS=D	<p>Bartelt, RN.</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility</p>			F0225	F- Tag 225 and F-Tag 226: Investigate and Report Allegations/Individuals: : It is the policy of Miller's Merry Manor,		08/07/2011

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	<p>failed to ensure a licensed nurse immediately removed a resident from a source of alleged abuse and assessed for injury for 1 of 2 residents with alleged violations of staff to resident abuse in a sample of 3 residents reviewed for use of a physical restraint. (Resident A)</p> <p>Findings include:</p> <p>During initial tour on July 07, 2011, at 9:40 a.m., Resident A was observed lying down in a low bed. A mat was positioned on the floor, beside the right and left side of the bed. A one-half side rail was positioned up, on the upper right side of the bed. A grab bar was positioned up, on the upper left side of the bed. Resident A was awake and independently moving about in the bed.</p> <p>Resident A's clinical records were reviewed on July 07, 2011, at 1:45 p.m.</p> <p>A Side Rail Assessment dated June</p>				<p>Mooresville to ensure all allegations of abuse are reported to the administrator of the facility and/or other officials in accordance with the State law through established procedures. The facility policy requires that all alleged violations are thoroughly investigated, and the facility must prevent further potential abuse while investigation is in progress. The results of all investigations must be reported to the administrator or other designee and to other officials in accordance with State law. A written report will be completed within 5 working days of incident and if the alleged violation is verified that appropriate corrective action. Resident #A: (who was not harmed) All allegations of abuse will be investigated; interventions implemented immediately to prevent further or potential abuse and will be reported per facility abuse prohibition policy and procedure. (Attachment A: <i>Abuse Prohibition, Reporting, and Investigation, resident abuse</i>)</p> <p>LPN # 5: All residents are at risk to be affected by the deficient practice. LPN # 5 was disciplined, counseled, and educated on proper procedures. LPN #1 was disciplined, counseled, and put on final notice for putting a sheet on the side rail. As for the C.N.A., she was counseled/ in-serviced along with all other staff on proper abuse</p>		

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	<p>26, 2011, indicated, "Are side rails of ANY type used on bed? Yes. Type of rail(s) used? Half rails x [times] 2. Describe other: Upper half rails to be used as enabler. Check all reasons why this type of side rail(s) is used: Enables resident to reposition self in bed. Enables resident to get in and/or out of bed assisted or independently. The resident has been determined to be safe with the rail(s) up by one or more of the following: Able to use call light and request assistance into or out of bed. Does not attempt to climb over, around or through rails. Notification form signed by resident or responsible party for use of any type of side rails."</p> <p>The July 2011 Physician Orders indicated, "Ancillary Treatment orders: ASSISTIVE DEVICE - 1 1/2 side rail and 1 grab bar to be used as enabler. 6/27/2011 [date order initiated]"</p> <p>A cognitive assessment dated July 03, 2011, indicated a score of 6</p>				<p>procedures. D.O.N. or designee will monitor for any further reeducation needs/policy changes. An all staff in-service will be held on 7/22/2011 by the facility administrator or other designee to review the current policy for "Abuse Prohibition, Reporting, Investigation, resident abuse" procedures (Attachment A). Staff will be re-trained on the importance of ensuring resident safety immediately upon any observation or report of alleged abuse. Any allegations of resident abuse will be immediately communicated to supervisor after ensuring residents safety. A licensed nurse will complete a head to toe assessment and document any signs of harm or injuries. If a staff member is involved in the allegation then the staff member will be suspended and removed from the building during the investigation process. In the event of resident to resident abuse the residents will be separated immediately and if needed will remain under direct supervision until the immediate investigation is complete and resident safety is maintained. All allegations will be promptly communicated to the administrator or other designee. It will be the responsibility of the Administrator, DON, or other designee to report any allegation/report of abuse to the ISDH per facility policy and procedure via ISDH reporting</p>		

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	<p>[severe impairment]. Resident A was dependent on nursing staff for daily decision making.</p> <p>A functional status assessment dated July 03, 2011, indicated Resident A required extensive assistance from nursing staff for activities of daily living.</p> <p>The nursing schedule dated July 03, 2011, for Harrison Hall [unit Resident A resided] indicated LPN #1 and CNA #3 worked from 11:00 p.m. to 7:00 a.m.</p> <p>On July 07, 2011, at 10:50 a.m., CNA #3 was interviewed. During the interview CNA #3 indicated after initial rounds on July 03, 2011, LPN #1 reported having positioned a sheet on and/or over Resident A's right side rail, having done this for resident's safety. At around 4:00 a.m. to 4:30 a.m. CNA #3 entered the involved resident's room. No sheet was observed on either the side rail or the grab bar. Resident A was asleep with a sheet</p>				<p>form and follow-up with a full investigation/report within 5 days post the initial report. The facility will continue to complete monthly QA calls to resident families to also assist in monitoring the ongoing quality of care provided to our residents. Abuse educational information has been posted in various places throughout the facility such as the break room, employee bathrooms, time clock for ongoing employee reference. The facility will continue to provide in-service training to all staff upon new hire and at a minimum of twice a year regarding the facility policies for "Abuse". The QA tool titled "Resident Satisfaction Review" (Attachment B) will be reviewed with residents during the monthly resident council meeting by social services or other designee. Additionally, the "Resident Satisfaction Review" will be completed with 3 resident per week for the next 4 weeks then 3 residents per month for the next 3 months to monitor compliance. We have also added a monthly QA tool (Attachment C) as a system to monitor for abuse prevention for residents who are unable to make their needs known. This tool will be completed 1 time per week for the next 3 months then 1 time per month for the next 3 months. Any trends identified will result in immediate intervention/ re-education and will be recorded</p>		

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	<p>and comforter positioned on top of her, as one would normally sleep. CNA #3 indicated not, at any time, having observed a sheet on either the side rail and/or the grab bar of Resident A's bed.</p> <p>The nursing schedule dated July 04, 2011, for Harrison Hall indicated LPN #1 and CNA #2 worked from 11:00 p.m. to 7:00 a.m.</p> <p>On July 07, 2011, at 10:30 a.m. and at 11:20 a.m., CNA #2 was interviewed. During the interview CNA #2 indicated during initial rounds on July 04, 2011, she observed Resident A to be asleep in her bed. The right one-half side rail was positioned up. A twin sheet was tied to the side rail at the top of the top [having demonstrated the upper most position closest to the head of the bed] and to the top of the bottom [having demonstrated the upper most position closest to middle of the bed]. The sheet was observed to travel from the side rail to underneath the comforter</p>				on a QA log to be reviewed during the monthly facility QA meeting.		

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	<p>positioned on top of Resident A. CNA #2 did not touch nor look to see in what position the sheet was in, under the comforter. CNA #2 asked LPN #1 about her observation. LPN #1 indicated to CNA #2 she had positioned the sheet like that, for the safety of Resident A. CNA #2 was not comfortable with what she had seen and reported her observation to LPN #5.</p> <p>On July 07, 2011, at 2:55 p.m., LPN #5 was interviewed. During the interview LPN #5 indicated on July 04, 2011, she had gone to Resident A's room, due to being called to the room by CNA #2. Upon entering the room LPN #5 observed Resident A to be asleep in bed, lying on her left side. The right one-half side rail was positioned up. A twin sheet was tied to the side rail at the top of the top [having demonstrated the upper most position closest to the head of the bed] and to the top of the bottom [having demonstrated the</p>						

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	<p>upper most position closest to middle of the bed]. The sheet was observed to travel from the side rail to "over the top of Resident A." LPN #5 indicated not having looked further to see how the sheet had been positioned. LPN #5 indicated, "I thought it looked like the sheet was cradled around the resident," having again indicated, "I did not look to see the end of the sheet." LPN #5 then indicated having left Resident A's room without having ensured the sheet had been removed nor having assessed Resident A for injury. CNA #2 indicated to LPN #5, LPN #1 untied and removed the sheet.</p> <p>On July 07, 2011, at 11:00 a.m., LPN #1 was interviewed. During the interview LPN #1 indicated during initial rounds on July 04, 2011, she entered Resident A's room and observed her to be asleep in bed. Resident A's arm had slipped through the right side rail, which it had done in the past. With Resident A's cognitive and</p>						

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	<p>assistance with ADL's status LPN #1 had positioned, by having tied, a twin sheet to the right side rail and then pulled it toward the floor. The sheet was positioned between the side rail and the right side of the mattress, to prevent Resident A's arm from going through the rail and potentially being hurt.</p> <p>On July 07, 2011, just after lunch time the involved resident's family was interviewed. No concerns of care were verbalized.</p> <p>On July 08, 2011, at 1:25 p.m., Resident A was assessed by LPN #7. Resident A's family was present. No redness, no bruising, no complaints of pain upon touching of Resident A had been assessed. The family was again asked of any concerns related to Resident A's care and/or alleged restraint and/or confinement to the bed by use of a sheet. The family did not verbalize any concerns and indicated everything "is fine."</p>						

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	<p>The nursing facility's Abuse Prohibition, Reporting, and Investigation Policy(s) dated August 23, 2010, provided by the Administrator, indicated, "POLICY: It is the policy of _____ [facility name] that all residents have the right to be free from ... physical abuse. ... DEFINITIONS: ... abuse is defined as the willful infliction of injury, unreasonable confinement ... If resident abuse, or suspicion of abuse is reported: a. The resident(s) involved in the incident will be removed from the situation at once. The Charge Nurse will examine the resident(s) involved to determine if physical injuries have occurred, and to their extent."</p> <p>On July 07, 2011, at 3:30 p.m., the Administrator and Director of Nursing were interviewed. During the interview LPN #5's interview statement was reviewed, which indicated an alleged incident of LPN #1 having unreasonably confined and/or restrained Resident</p>						

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	<p>A with a sheet while in bed, on the night of July 04, 2011. LPN #5 then further indicated having failed to observe the placement of the sheet from the right side rail, to immediately remove Resident A from the alleged restraint, and to examine the resident to determine if a physical injury had occurred. The administrative staff, who were present during LPN #5's interview, indicated LPN #5 failed to immediately remove an alleged physical restraint and assess the resident for injury.</p> <p>On July 08, 2011, the Administrator provided a Disciplinary Detail dated July 08, 2011. The Disciplinary Detail indicated LPN #5 received disciplinary action for having failed to remove a resident from an alleged physical restraint at once and having failed to assess the resident for injury(s).</p> <p>This federal tag is related to Complaint IN00093118.</p>						

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F0226 SS=D	3.1-28(d) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure a resident was immediately removed from a source of alleged abuse and assessed for injury as indicated by the facility's Abuse Prohibition, Reporting, and Investigation Policy(s) for 1 of 2 residents with alleged violations of staff to resident abuse in a sample of 3 residents reviewed for use of a physical restraint. (Resident A) Findings include: During initial tour on July 07, 2011, at 9:40 a.m., Resident A was observed lying down in a low bed. A mat was positioned on the floor, beside the right and left side of the bed. A one-half side rail was positioned up, on the upper right side of the bed. A grab bar was positioned up, on the upper left side of the bed. Resident A was awake and independently moving about in the bed.			F0226	F- Tag 225 and F-Tag 226: Investigate and Report Allegations/Individuals: : It is the policy of Miller's Merry Manor, Mooresville to ensure all allegations of abuse are reported to the administrator of the facility and/or other officials in accordance with the State law through established procedures. The facility policy requires that all alleged violations are thoroughly investigated, and the facility must prevent further potential abuse while investigation is in progress. The results of all investigations must be reported to the administrator or other designee and to other officials in accordance with State law. A written report will be completed within 5 working days of incident and if the alleged violation is verified that appropriate corrective action. Resident #A: (who was not harmed) All allegations of abuse will be investigated; interventions implemented immediately to		08/07/2011

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	<p>Resident A's clinical records were reviewed on July 07, 2011, at 1:45 p.m.</p> <p>A Side Rail Assessment dated June 26, 2011, indicated, "Are side rails of ANY type used on bed? Yes. Type of rail(s) used? Half rails x [times] 2. Describe other: Upper half rails to be used as enabler. Check all reasons why this type of side rail(s) is used: Enables resident to reposition self in bed. Enables resident to get in and/or out of bed assisted or independently. The resident has been determined to be safe with the rail(s) up by one or more of the following: Able to use call light and request assistance into or out of bed. Does not attempt to climb over, around or through rails. Notification form signed by resident or responsible party for use of any type of side rails."</p> <p>The July 2011 Physician Orders indicated, "Ancillary Treatment orders: ASSISTIVE DEVICE - 1 1/2 side rail and 1 grab bar to be used as enabler. 6/27/2011 [date order initiated]"</p> <p>A cognitive assessment dated July 03, 2011, indicated a score of 6 [severe impairment]. Resident A was dependent on nursing staff for daily decision making.</p>				<p>prevent further or potential abuse and will be reported per facility abuse prohibition policy and procedure. (Attachment A: <i>Abuse Prohibition, Reporting, and Investigation, resident abuse</i>)</p> <p>LPN # 5: All residents are at risk to be affected by the deficient practice. LPN # 5 was disciplined, counseled, and educated on proper procedures. LPN #1 was disciplined, counseled, and put on final notice for putting a sheet on the side rail. As for the C.N.A., she was counseled/ in-serviced along with all other staff on proper abuse procedures. D.O.N. or designee will monitor for any further reeducation needs/policy changes. An all staff in-service will be held on 7/22/2011 by the facility administrator or other designee to review the current policy for "Abuse Prohibition, Reporting, Investigation, resident abuse" procedures (Attachment A). Staff will be re-trained on the importance of ensuring resident safety immediately upon any observation or report of alleged abuse. Any allegations of resident abuse will be immediately communicated to supervisor after ensuring residents safety. A licensed nurse will complete a head to toe assessment and document any signs of harm or injuries. If a staff member is involved in the allegation then the staff member will be suspended and removed from the building</p>		

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	<p>A functional status assessment dated July 03, 2011, indicated Resident A required extensive assistance from nursing staff for activities of daily living.</p> <p>The nursing schedule dated July 03, 2011, for Harrison Hall [unit Resident A resided] indicated LPN #1 and CNA #3 worked from 11:00 p.m. to 7:00 a.m.</p> <p>On July 07, 2011, at 10:50 a.m., CNA #3 was interviewed. During the interview CNA #3 indicated after initial rounds on July 03, 2011, LPN #1 reported having positioned a sheet on and/or over Resident A's right side rail, having done this for the resident's safety. At around 4:00 a.m. to 4:30 a.m. CNA #3 entered the involved resident's room. No sheet was observed on either the side rail or the grab bar. Resident A was asleep with a sheet and comforter positioned on top of her, as one would normally sleep. CNA #3 indicated not, at any time, having observed a sheet on either the side rail and/or the grab bar of Resident A's bed.</p> <p>The nursing schedule dated July 04, 2011, for Harrison Hall indicated LPN #1 and CNA #2 worked from 11:00 p.m. to 7:00 a.m.</p> <p>On July 07, 2011, at 10:30 a.m. and at 11:20 a.m., CNA #2 was interviewed.</p>				<p>during the investigation process. In the event of resident to resident abuse the residents will be separated immediately and if needed will remain under direct supervision until the immediate investigation is complete and resident safety is maintained. All allegations will be promptly communicated to the administrator or other designee. It will be the responsibility of the Administrator, DON, or other designee to report any allegation/report of abuse to the ISDH per facility policy and procedure via ISDH reporting form and follow-up with a full investigation/report within 5 days post the initial report. The facility will continue to complete monthly QA calls to resident families to also assist in monitoring the ongoing quality of care provided to our residents. Abuse educational information has been posted in various places throughout the facility such as the break room, employee bathrooms, time clock for ongoing employee reference. The facility will continue to provide in-service training to all staff upon new hire and at a minimum of twice a year regarding the facility policies for "Abuse". The QA tool titled "Resident Satisfaction Review" (Attachment B) will be reviewed with residents during the monthly resident council meeting by social services or other designee. Additionally, the</p>		

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	<p>During the interview CNA #2 indicated during initial rounds on July 04, 2011, she observed Resident A to be asleep in her bed. The right one-half side rail was positioned up. A twin sheet was tied to the side rail at the top of the top [having demonstrated the upper most position closest to the head of the bed] and to the top of the bottom [having demonstrated the upper most position closest to middle of the bed]. The sheet was observed to travel from the side rail to underneath the comforter positioned on top of Resident A. CNA #2 did not touch nor look to see in what position the sheet was in, under the comforter. CNA #2 asked LPN #1 about her observation. LPN #1 indicated to CNA #2 she had positioned the sheet like that, for the safety of Resident A. CNA #2 was not comfortable with what she had seen and reported her observation to LPN #5.</p> <p>On July 07, 2011, at 2:55 p.m., LPN #5 was interviewed. During the interview LPN #5 indicated on July 04, 2011, she had gone to Resident A's room, due to being called to the room by CNA #2. Upon entering the room LPN #5 observed Resident A to be asleep in bed, lying on her left side. The right one-half side rail was positioned up. A twin sheet was tied to the side rail at the top of the top [having demonstrated the upper most</p>				<p>"Resident Satisfaction Review" will be completed with 3 resident per week for the next 4 weeks then 3 residents per month for the next 3 months to monitor compliance. We have also added a monthly QA tool (Attachment C) as a system to monitor for abuse prevention for residents who are unable to make their needs known. This tool will be completed 1 time per week for the next 3 months then 1 time per month for the next 3 months. Any trends identified will result in immediate intervention/ re-education and will be recorded on a QA log to be reviewed during the monthly facility QA meeting.</p>		

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	<p>position closest to the head of the bed] and to the top of the bottom [having demonstrated the upper most position closest to middle of the bed]. The sheet was observed to travel from the side rail to "over the top of Resident A." LPN #5 indicated not having looked further to see how the sheet had been positioned. LPN #5 indicated, "I thought it looked like the sheet was cradled around the resident," having again indicated, "I did not look to see the end of the sheet." LPN #5 then indicated having left Resident A's room without having ensured the sheet had been removed nor having assessed Resident A for injury. CNA #2 indicated to LPN #5, LPN #1 untied and removed the sheet.</p> <p>On July 07, 2011, at 11:00 a.m., LPN #1 was interviewed. During the interview LPN #1 indicated during initial rounds on July 04, 2011, she entered Resident A's room and observed her to be asleep in bed. Resident A's arm had slipped through the right side rail, which it had done in the past. With Resident A's cognitive and assistance with ADL's status LPN #1 had positioned, by having tied, a twin sheet to the right side rail and then pulled it toward the floor. The sheet was positioned between the side rail and the right side of the mattress, to prevent Resident A's arm from going through the rail and potentially being hurt.</p>						

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	<p>On July 07, 2011, just after lunch time the involved resident's family was interviewed. No concerns of care were verbalized.</p> <p>On July 08, 2011, at 1:25 p.m., Resident A was assessed by LPN #7. Resident A's family was present. No redness, no bruising, no complaints of pain upon touching of Resident A had been assessed. The family was again asked of any concerns related to Resident A's care and/or alleged restraint and/or confinement to the bed by use of a sheet. The family did not verbalize any concerns and indicated everything "is fine."</p> <p>The nursing facility's Abuse Prohibition, Reporting, and Investigation Policy(s) dated August 23, 2010, provided by the Administrator, indicated, "POLICY: It is the policy of _____ [facility name] that all residents have the right to be free from ... physical abuse. ... DEFINITIONS: ... abuse is defined as the willful infliction of injury, unreasonable confinement ... If resident abuse, or suspicion of abuse is reported: a. The resident(s) involved in the incident will be removed from the situation at once. The Charge Nurse will examine the resident(s) involved to determine if physical injuries have occurred, and to their extent."</p>						

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	<p>On July 07, 2011, at 3:30 p.m. the Administrator and Director of Nursing were interviewed. During the interview LPN #5's interview statement was reviewed, which indicated an alleged incident of LPN #1 having unreasonably confined and/or restrained Resident A with a sheet while in bed, on the night of July 04, 2011. LPN #5 then further indicated having failed to observe the placement of the sheet from the right side rail, to immediately remove Resident A from the alleged restraint, and to examine the resident to determine if a physical injury had occurred. The administrative staff, who were present during LPN #5's interview, indicated LPN #5 failed to appropriately implement their abuse prohibition policy(s).</p> <p>On July 08, 2011, the Administrator provided a Disciplinary Detail dated July 08, 2011. The Disciplinary Detail indicated LPN #5 received disciplinary action for having violated the facility's Abuse Prohibition, Reporting, and Investigation Policy(s) dated August 23, 2010.</p> <p>This federal tag is related to Complaint IN00093118.</p>						

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